Supreme Court, U.S.
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No. 93-1349

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

DAVID L. RAMSEY, SECRETARY,
DEPARTMENT OF HEALTH AND HOSPITALS,
STATE OF LOUISIANA, *et al.*,
Petitioners,

v.

ABBEVILLE GENERAL HOSPITAL, *et al.*,
Respondents.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Boren Amendment to the Medicaid Act requires participating States to provide for payment for hospital services "through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards." 42 U.S.C. § 1396a(a)(13)(A). The questions presented are:

1. Whether the court of appeals, in reviewing whether the State complied with the procedural requirement that it "find[]" that its rates are reasonable and adequate, erred in conducting a *de novo* review of the quality of the State's "factfinding process," the "quantum of evidence" that supported the State's findings, and aspects of the State's rate-setting methodology.

2. Whether this Court should reconsider its decision in *Wilder* v. *Virginia Hospital Association*, 496 U.S. 498 (1990), that the Boren Amendment can be enforced by health care providers through an action under 42 U.S.C. § 1983.

PARTIES TO THE PROCEEDING

The petitioners are David L. Ramsey, Christopher Pilley, Carolyn Maggio, Howard Prejean, and Helene Robinson.

The respondents are:

Abbeville General Hospital
American Legion Hospital
Baton Rouge General Medical Center
Beauregard Memorial Hospital
Bogalusa Community Medical Center
Bunkie General Hospital
Dauterive Hospital
East Jefferson General Hospital
Glenwood Regional Medical Center
HCA North Monroe Hospital
Humana Hospital-Lake Charles
Humana Hospital-Marksville
Humana Hospital-Oakdale
Humana Hospital-Springhill
Humana Hospital-Ville Platte
Humana Hospital-Winn Parish
Jennings American Legion Hospital
Lady of the Sea General Hospital
Lafayette General Medical Center
Lake Charles Memorial Hospital
Lakeside Hospital
Lakewood Hospital
Lane Memorial Hospital
LaSalle General Hospital
Lincoln General Hospital
Madison Parish Hospital
Medical Center of Baton Rouge
Opelousas General Hospital
1Our Lady of Lourdes Hospital

Our Lady of the Lake Hospital
Pendleton Memorial Methodist Hospital
Rapides General Hospital
Richland Parish Hospital-Delhi
Richardson Medical Center a/k/a Richland Parish Hospital-Rayville
Riverside Medical Center
St. Ann General Hospital
St. Francis Medical Center
St. Patrick Hospital of Lake Charles
St. Tammany Parish Hospital
Schumpert Medical Center
Seventh Ward General Hospital
Slidell Memorial Hospital
Sterlington Hospital, Inc.
Thibodaux Hospital & Health Centers
Touro Infirmary
Tulane University Medical Center
Union General Hospital
West Calcasieu-Cameron Hospital
Women's & Children's Hospital

TABLE OF CONTENTS

	Page
OPINIONS BELOW	2
JURISDICTION	2
STATUTES AND REGULATIONS INVOLVED	2
STATEMENT	2
REASONS FOR GRANTING THE PETITION	9
I. THE COURT OF APPEALS' DECISION IS CONTRARY TO THE PLAIN LANGUAGE OF THE BOREN AMENDMENT AND CONFLICTS WITH DECISIONS OF THIS COURT AND OTHER COURTS OF APPEALS	10
A. *The Court of Appeals' Decision Is Contrary to the Plain Language of the Statute and this Court's Decision in Wilder*	10
B. *The Decision Adds to the Confusion in the Courts of Appeals Over the Standard of Judicial Review in Boren Amendment Cases*	13

C. *The Court of Appeals' Decision Is Contrary to the Principle That Courts May Not Impose Procedural Requirements on Agencies* 15

II. THE COURT SHOULD RECONSIDER ITS DECISION IN *WILDER* 17

CONCLUSION 22

APPENDIX A 1a

APPENDIX B 29a

APPENDIX C 36a

APPENDIX D 38a

TABLE OF AUTHORITIES

Cases

Amisub (PSL), Inc. v. Colorado Department of Social Services, 879 F.2d 789 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990) 14, 19

Anco, Inc. v. State Health & Human Service Finance Commission, 388 S.E.2d 780 (S.C. 1989) 20

Andrews v. Louisville & N.R.R. Co., 406 U.S. 320 (1972) 17

Arkansas Medical Soc'y, Inc. v. *Reynolds*, 6 F.3d 519, 524 (8th Cir. 1993) 19

Boys Markets, Inc. v. Retail Clerks Union, Local 770, 398 U.S. 235 (1970) 18

Braden v. 30th Judicial Circuit Court, 410 U.S. 484 (1973) 17

Burnet v. Coronado Oil & Gas Co., 285 U.S. 393 (Brandeis, J., dissenting) 17

Camp v. Pitts, 411 U.S. 138 (1973) 17

Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402 (1971) 17

Colorado Health Care Association v. Colorado Department of Social Servs., 842 F.2d 1158 (10th Cir. 1988) 20

Continental T.V., Inc. v. GTE Sylvania Inc., 433 U.S. 36 (1977) 17

FCC v. Pottsville Broadcasting Co., 309 U.S. 134 (1940) 16

FCC v. Schreiber, 381 U.S. 279 (1965) 16

Folden v. Washington State Department of Social & Health Services, 981 F.2d 1054 (9th Cir. 1992) 16, 19

Harris v. McRae, 448 U.S. 297 (1980) 2

Illinois Health Care Association v. Bradley, 983 F.2d 1460 (7th Cir. 1993) 15, 19, 20

Lett v. Magnant, 965 F.2d 251 (7th Cir. 1992) 19

Lodge 76, International Association of Machinists v. Wisconsin Employment Relations Comm'n, 427 U.S. 132 (1976) 17

Mary Washington Hospital, Inc. v. Fisher, 635 F. Supp. 891 (E.D. Va. 1985) 12, 20

Mississippi Hospital Association, Inc. v. Heckler, 701 F.2d 511 (1983) 19

Monell v. Department of Social Services, 436 U.S. 658 (1978) 17

Multicare Medical Center v. Washington, 768 F. Supp. 1349 (D. Wash. 1991) 20

Nebraska Health Care Association v. Dunning, 778 F.2d 1291 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987) 19

Patterson v. McLean Credit Union, 491 U.S. 164 (1989) 17, 18, 19

Payne v. Tennessee, 111 S. Ct. 2597 (1991) 17

Pennhurst State School & Hospital v. Halderman, 451 U.S. 1 (1981) 18

Peyton v. Rowe, 391 U.S. 54 (1968) 18

Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306 (2d Cir. 1991) 13, 19

Square D Co. v. Niagara Frontier Tariff Bureau, Inc., 476 U.S. 409 (1986) 17

Suter v. Artist M, 112 S. Ct. 1360 (1992) 10, 18, 19

Temple University v. White, 941 F.2d 201 (3d Cir. 1991), *cert. denied*, 112 S. Ct. 873 (1992) 19

Vermont Yankee Nuclear Power Corp. v. Natural Resources Defense Council, 435 U.S. 519 (1978) 15, 16

West Virginia University Hospitals, Inc. v. Casey, 885 F.2d 11 (3d Cir. 1989), *aff'd on other grounds*, 499 U.S. 83 (1991) 14, 19

Wilder v. Virginia Hospital Association, 496 U.S. 498 (1990) . . . . . passim

Wisconsin Hospital Association v. Reivitz, 733 F.2d 1226 (1984) 13, 19

Statutes and Regulations

5 U.S.C. §551(1) 12

5 U.S.C. 557(b)(3)(A) 12

28 U.S.C. § 1254(1) 2

42 U.S.C. § 671(a)(15) 18

42 U.S.C. § 1983 . . . . . 2, 9, 10, 17, 18, 21

42 U.S.C. § 1396a(a)(13)(A) 2, 3, 10

42 C.F.R. §447.253 3

42 C.F.R. § 447.271 4

Miscellaneous

48 Fed. Reg. 56047-56049 19

Webster's Third New International Dictionary 852 (1968) 11

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ON PETITION FOR A WRIT OF CERTIORARI
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FOR THE FIFTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Petitioners David L. Ramsey, *et al.*, petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-28a) is reported at 3 F.3d 797. The opinion of the district court (App., *infra*, 29a-35a) is not reported.

JURISDICTION

The judgment of the court of appeals was entered on September 22, 1993. A petition for rehearing was denied, and the opinion was amended, on November 26, 1993. Pet. App. 36a-37a. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1) (1988).

STATUTES AND REGULATIONS INVOLVED

Relevant provisions of 42 U.S.C. § 1396a(a)(13)(A), 42 U.S.C. § 1983, and 42 C.F.R. § 447 are reprinted at App., *infra*, 38a-41a.

STATEMENT

1. Medicaid is a cooperative federal-state program established by Congress "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980). If a State elects to participate in the program, it must comply with the requirements of the Medicaid Act and regulations promulgated by the Secretary of Health and Human Services. *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990).

Section 1902(a)(13) of the Medicaid Act sets out the requirements for reimbursement of health care providers. That section, as amended by the Boren Amendment, provides that a participating State's plan for medical assistance must

> provide . . . for payment . . . of the hospital services . . . through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality.

42 U.S.C. § 1396a(a)(13)(A) (1988) ("Boren Amendment").

The Secretary has promulgated regulations pursuant to the Boren Amendment that require participating States to provide "assurances" whenever a State Medicaid Plan is submitted to the Secretary for initial approval or amended. 42 C.F.R. § 447.253 (1992). In addition, the Secretary's regulations require participating States to make specified findings "[w]henever the Medicaid agency makes a change in its methods and standards, but not less often than annually." *Id.*

2. In 1983, soon after the enactment of the Boren Amendment, Louisiana adopted a new payment system for Medicaid inpatient hospital services. Louisiana's Department of Health and Hospitals ("LDHH") submitted its proposed plan to the federal Health Care Financing Administration ("HCFA"), with assurances that it had found that the reimbursement rates were adequate to meet the costs that must be incurred by efficiently and economically operated hospitals. The Secretary, acting through HCFA, approved the plan.

Under Louisiana's system, hospitals are reimbursed for 100 percent of all capital costs, educational expenses incurred by teaching hospitals, and malpractice expenses. The hospitals' remaining operating costs are reimbursed at a level determined by each hospital's "target rate." A hospital is reimbursed for 100 percent of its operating costs as long as the costs remain below the hospital's target rate; the hospital is not reimbursed for costs in excess of its target rate. The target rate thus provides hospitals with an incentive to control their operating costs.

Each hospital's initial target rate was based on its actual average operating cost per Medicaid discharge in 1980 or 1981, whichever was higher. In 1982, 1983, and 1984, Louisiana increased the target rates in accordance with a nationwide price index published by HCFA that tracks price changes for a "market basket" of goods and services purchased by hospitals. LDHH made an additional 1 percent upward adjustment in 1982 and 1983, and an additional 1/4 percent upward adjustment in 1984. During this period, Louisiana paid Medicaid providers the highest rates permitted under HCFA regulations.[1/]

In 1985 and 1986, LDHH amended its Medicaid plan to provide that there would be no increases in the target rates for cost periods beginning July 1, 1985, and ending June 30, 1987. The HCFA indices for 1985 and 1986 were, respectively, 0.21 percent and 1.15 percent. LDHH found it unnecessary to implement these small increases because the State's depressed economy restrained cost inflation, and

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[1/] The Boren Amendment places only a lower limit on Medicaid reimbursement rates; other provisions of the Medicaid Act and accompanying regulations place upper limits on Medicaid reimbursement rates. See 42 C.F.R. § 447.271 (upper limits based on customary charges); *id.* § 447.272 (upper limits based on Medicare principles).

because the target rates were so high in relation to actual hospital costs in Louisiana that they provided little incentive to control costs. The 1985 and 1986 amendments were submitted to HCFA with assurances that LDHH had found that the amended State Plan would result in rates that were adequate to meet costs that must be incurred by efficiently and economically operated hospitals. HCFA approved the amendments.

In 1988, the State amended its Medicaid plan to provide that target rates would not be increased for cost periods beginning July 1, 1988. LDHH's decision was based in large part on two factors. First, HCFA's national cost index was producing target rate increases that were too large for Louisiana, where economic conditions were depressed. Second, a freeze in the target rate was necessary to strengthen the State Plan's cost containment incentives, and to counteract increasing inefficiency in Louisiana's hospital industry. The amendment was submitted to HCFA with assurances that LDHH had found that the rates were reasonable and adequate under the Boren Amendment. The acting administrator of HCFA disapproved the amendment; an administrative appeal of that decision is pending.

The temporary freeze of target rates ended in 1990. Thereafter, target rates were increased by the amount of the HCFA index, or about 5 percent per year.

3. Respondents, 58 hospitals located in Louisiana, brought this action in 1991 alleging that petitioners had not complied with the requirements of the Boren Amendment. The district court granted petitioners' motion for summary judgment. The court, applying an arbitrary and capricious standard of review to "a state Medicaid agency's actions under the Boren Amendment," App., *infra*, 31a, held that the State had "adequately and properly set forth findings for the

decision it made in adopting changes in its plan during the years 1985, 1986, 1988, 1989, and 1990." *Id.* The court noted that "[t]he evidence submitted by [petitioners] is uncontroverted." *Id.*

4. The court of appeals reversed and ordered LDHH "to engage in a *bona fide* findings process." App., *infra*, 26a. The court first held that "[w]hether LDHH complied with the procedural requirements of the Boren Amendment is a question of law, subject to *de novo* review." *Id.* at 8a (citation omitted). Although the court acknowledged "a litany of cases for the indisputable proposition that a state agency's rate-setting action is entitled to considerable deference," *id.* at 7a, it concluded that "most" courts apply a *de novo* standard in reviewing compliance with the procedural requirements of the Boren amendment. The court acknowledged, however, that one court of appeals "review[s] . . . procedural compliance with the findings and assurances requirement under the arbitrary and capricious standard," *id.* at 8a n.7 (citing *Illinois Health Care Association* v. *Bradley*, 983 F.2d 1460, 1462-63 (1993)), and added that there is "bedlam" in the courts of appeals concerning the appropriate standard for reviewing substantive compliance with the findings requirement. *Id.* The court of appeals adopted a "two-step review process — *de novo* review of the state's fact-finding process and arbitrary and capricious review of the findings and rates." *Id.* at 11a.

The court acknowledged that "LDHH had made its findings and submitted assurances to HCFA for approval of its initial Medicaid plan in 1984 and all subsequent amendments to the plan's reimbursement rates." App., *infra*, 7a. The court nevertheless held that LDHH failed to make "findings in compliance with the Boren Amendment procedural requirements." *Id.* at 12a. The court observed that "[w]hat constitutes a Medicaid Act 'finding' has been defined in

different ways" by different courts. *Id.* at 14a. The court said that the finding issue turned on the following question:

> [W]hat is the minimum quantum of evidence that an agency must possess in its cognition to substantiate its assurances that the reimbursement rates in the Medicaid plan and any proposed amendments (1) reasonably and adequately meet the costs that must be incurred by efficiently and economically operated hospitals, (2) accommodate hospitals serving a disproportionate number of low income patients with special needs, and (3) adequately ensure that Medicaid recipients have reasonable access to inpatient hospital services of adequate quality.

Id. at 15a-16a. The court did not attempt to define the "minimum quantum of evidence that [a state] agency must possess," except to state that the agency "must show it conducted an objective analysis, evaluation, or some type of factfinding process." *Id.* at 16a.

The court then rejected petitioners' contention that Louisiana engaged in ongoing analyses of the adequacy of rates. The court did not question testimony by a LDHH official that she had examined "how costs had increased from the base period to the current audited period versus how the average target rate had increased in that same period of time" and determined that "the increases in the target rates were greater than the actual increases in costs." App., *infra*, 21a.[2/] But the court concluded that the State's "efforts . . . to satisfy the findings requirement" were inadequate, *id.*

[2/] In a footnote, the court listed 11 categories of information that state officials had considered before changing Medicaid reimbursement rates. App., *infra*, 19a-20a n.15.

at 21a n.15, and stated: (1) "[t]he 'costs' compared were the hospitals' total cost per discharge, without any separation of labor costs or other cost components"; (2) the State did not examine data from all hospitals, and did not employ "scientific methodology to determine that the hospitals reviewed were representative," and (3) the responsible state official "based the 'process' on what she thought was right based on her experience" and did not reduce her analysis to writing. *Id.* at 21a. The court stated that it was "not concerned with the adequacy of the [the State's] alleged 'findings,' but with LDHH's fact-gathering procedures." *Id.* at 20a n.15.

The court further concluded that "the method by which LDHH promulgated the initial target rates fails the Boren Amendment test." App., *infra*, 19a. The court stated that, because "each hospital's target rate initially included all allowable base year costs, without 'limit[] or cap[] in any respect to remove inefficient, uneconomic, or unnecessary costs,'" hospitals could be "deemed efficient and economic, even though they might have . . . some continued inefficiencies." *Id.* at 24a. The court stated that there was a "fallacy" in this methodology based on its conclusion that "[b]y enacting the Boren Amendment, Congress intended states to abandon . . . schemes that paid actual hospital costs." *Id.*

The court concluded that LDHH's "inability to articulate an orderly process of evaluation or to identify specific documents reviewed renders suspect its 'findings' and renders meritless its argument that it engaged in a *bona fide* findings process." App., *infra*, 27a. Accordingly, the court reversed the judgment of the district court and "order[ed] LDHH to engage in a *bona fide* findings process." *Id.* at 26a-27a.

REASONS FOR GRANTING THE PETITION

The court of appeals engaged in an intensive and wholly unwarranted review of the State's internal decisionmaking process under the guise of determining whether the State had complied with the straightforward procedural requirement that it "find" that its rates are reasonable and adequate. In *Wilder*, this Court observed that the Boren Amendment imposes only "bare" and "perfunctory" procedural requirements. 496 U.S. at 510, 513. It is undisputed that the responsible state officials at all required times "found" that the State's rates were reasonable and adequate, and submitted written assurances to that effect to the Secretary. The court of appeals' decision that this did not satisfy the procedural requirements of the Boren Amendment is contrary to the plain language of the statute and the statements of this Court in *Wilder*. In addition, the court of appeals disregarded the principle that courts should not engraft procedural requirements on agencies entrusted with substantive functions by Congress.

The court's additional conclusion that it was appropriate to determine under a *de novo* standard of review whether the State had engaged in an adequate "factfinding process" was a completely unwarranted expansion of the court's role in enforcing the Boren Amendment and is in apparent conflict with a decision of another court of appeals. The court's further conclusion that the State's basic rate-setting methodology is flawed went far beyond the proper boundaries of judicial review of procedural compliance with the "findings" requirement.

This case is one of many that has been brought under 42 U.S.C. § 1983 as a result of this Court's decision in *Wilder*. Judicial enforcement of the vague standards of the Boren Amendment has proved to be unworkable and disruptive.

Ironically, although the Boren Amendment was intended to reduce federal agency oversight of the ratesetting process, it is now providing for very extensive oversight by the federal courts. Moreover, *Wilder*'s conceptual underpinnings have been weakened by the Court's recent decision in *Suter* v. *Artist M*, 112 S. Ct. 1360 (1992). Accordingly, this case presents an appropriate opportunity for the Court to reconsider whether the Boren Amendment can be enforced by health care providers through an action under 42 U.S.C. § 1983.

I. THE COURT OF APPEALS' DECISION IS CONTRARY TO THE PLAIN LANGUAGE OF THE BOREN AMENDMENT AND CONFLICTS WITH DECISIONS OF THIS COURT AND OTHER COURTS OF APPEALS.

A. *The Court of Appeals' Decision Is Contrary to the Plain Language of the Statute and this Court's Decision in Wilder.*

The Boren Amendment requires that a State must "*find*[], and make assurances satisfactory to the Secretary," that its rates are reasonable and adequate. 42 U.S.C. § 1396a(a)(13)(A)(1988) (emphasis added). In *Wilder*, the Court distinguished between a "mere[] . . . procedural [right] that rates be accompanied by findings and assurances (however perfunctory) of reasonableness and adequacy" and "a substantive right to reasonable and adequate rates." 496 U.S. at 510. In drawing that distinction, the Court observed that the Amendment imposes only "bare procedural requirements." *Id.* at 513. See also *id.* at 527 (Rehnquist, C.J., dissenting) (Boren Amendment "establishes a procedure . . . . The first step requires the States to make certain findings. The second and only other step requires the States to make certain assurances to the Secretary and the Secretary — not the courts — to review those assurances").

The court of appeals reviewed only the State's compliance with the procedural requirements of the Amendment, which relate to the requirement that the State "find" that its rates are reasonable and adequate.[3/] But the court read the Boren Amendment as requiring far more than the "bare" requirement that "rates be accompanied by findings . . . (however perfunctory)." 496 U.S. at 510. According to the court of appeals, the word "finds" incorporates a requirement that the State engage in a "factfinding process" that generates a "minimum quantum of evidence . . . to substantiate [the State's] assurances." App., *infra*, 15a-16a. The court did not define what this required of a State, but held that Louisiana's approach of relying on the judgment of experienced state officials who analyzed hospital cost reports and other information was not sufficient.

The court's reading of the Boren Amendment is contrary to the ordinary meaning of the term "find." To "find" is "to arrive at (a conclusion)" or to "determine and declare (as a verdict in a judicial proceeding)." *Webster's Third New International Dictionary* 852 (1968). The court of appeals confused *whether* the State arrived at a finding that its rates were reasonable and adequate with *how* and *why* the State arrived at that conclusion. The latter issues simply are not relevant to the "bare procedural requirement" that the State make findings.[4/]

[3/] The court did not hold that the State failed to comply with the "assurances" requirement. To the contrary, it found that the State "submitted assurances to HCFA for approval of its initial Medicaid plan in 1984 and all subsequent amendments to the plan's reimbursement rates." App., *infra*, 7a.

[4/] The distinction between findings and the bases for findings is reflected in Section 8(b) of the Administrative Procedure Act, which applies to (continued...)

Under the guise of determining whether the State had complied with the procedural "finding" requirement, the court of appeals engaged in an extensive *de novo* review of various aspects of the State's ratemaking activities. It conducted the equivalent of review of agency action under the Administrative Procedure Act — *i.e.*, the court considered whether the State had compiled an administrative record that contained evidence sufficient to support the agency's rate decisions — without giving the State the benefit of a deferential standard of review.[5/] The court went so far as to conclude that there was a "fallacy in LDHH's rate-setting methodology," even though the rate-setting system had been approved by HCFA in 1983, seven years before the lawsuit was even filed.[6/] App., *infra*,

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[4/](...continued)
formal adjudications, and requires a statement of "findings and conclusions, *and* the reasons or basis therefor." 5 U.S.C. § 557(b)(3)(A) (emphasis added). Of course, the APA does not apply to this case, because the State of Louisiana is not a federal agency. See 5 U.S.C. § 551(1); *Mary Washington Hosp., Inc.* v. *Fisher*, 635 F. Supp. 891, 897 (E.D. Va. 1985). *Cf. Wilder*, 496 U.S. at 514 n.12 (discussing possibility that providers may be able to bring an action under the APA against the Secretary of Health and Human Services).

[5/] The court stated that LDHH (1) compared hospitals' total cost per Medicaid discharge, without comparing labor costs and other components of total cost; (2) failed to examine audited data from all Louisiana hospitals, or to use a "scientific methodology" to determine that the hospitals whose costs were reviewed were a representative sample; and (3) allowed state officials to act on the basis of their experience, and relied on information and analysis that was not reduced to writing. App., *infra*, 21a.

[6/] The supposed "fallacy in LDHH's rate-setting methodology" was that LDHH permitted rates to exceed an amount necessary to cover the costs that must be incurred by efficiently and economically operated hospitals. App., *infra*, 23a-24a. In fact, there was no "fallacy". The Boren
(continued...)

24a. In effect, the court converted a "bare" procedural requirement into a requirement entailing intrusive *de novo* judicial review of a wide range of rate-related matters. This erroneous expansion of the scope of review in a Boren Amendment case warrants review by this Court.

B. *The Decision Adds to the Confusion in the Courts of Appeals Over the Standard of Judicial Review in Boren Amendment Cases.*

Although this Court in *Wilder* declined to set forth the "the appropriate standard of review" in a Boren Amendment case, it observed that courts of appeals had generally "employ[ed] a deferential standard of review to evaluate whether the rates comply with the substantive requirements of the amendment." 496 U.S. at 520 n.18 (citing cases). As the court of appeals observed, App., *infra*, 9a & n.8, the courts of appeals are now in a state of "bedlam" concerning the appropriate standard for reviewing substantive compliance with the Boren Amendment.[7/] The court of appeals thought

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[6/](...continued)
Amendment prohibits States from paying *less* than the amount specified in the statute, but it does not prevent them from paying *more*. In this regard, the court's decision conflicts with the decision of the Seventh Circuit in *Wisconsin Hospital Ass'n* v. *Reivitz*, 733 F.2d 1226, 1233 (1984) which recognized that a State, in providing assurances under the Boren Amendment, "is merely . . . saying that, at the least, its plan conforms to federal requirements; the state does not certify that these rates are *only* or *barely* adequate".

[7/] Although some courts engage in "deferential[]" review, at least when the Secretary has accepted the State's assurances, see *Pinnacle Nursing Home* v. *Axelrod*, 928 F.2d 1306, 1313 (2d Cir. 1991), others do not. For example, the Third Circuit has held that it will apply the arbitrary and capricious standard to determine whether rates are "reasonable and (continued...)

it was escaping the bedlam and aligning itself with "most" other circuits by holding that the State's compliance "with the procedural requirements of the Boren Amendment is a question of law, subject to *de novo* review." App., *infra*, 8a. In fact, the procedural requirement is not a "question of law" — either the State made the requisite finding or it did not. Further, the court did not confine its *de novo* review to the "bare" procedural issue of whether a finding had been made, but examined on a *de novo* basis the adequacy of the State's "factfinding process" and even opined on whether there were "fallacies" in the underlying rate-setting methodology.

The application of a *de novo* standard of review was completely inconsistent with the court's expansive definition of the "procedural" finding requirement, a definition that included the quality of the State's "factfinding process," its "fact-gathering procedures" and the "quantum of evidence that [the] agency . . . possess[ed] in its cognition to substantiate its assurances." App., *infra*, 15a, 20a n.15. Other courts have made the same mistake, with the result that many States are now subject to an unwarranted, unintended and highly intrusive level of judicial review. See, *e.g.*, *Amisub (PSL), Inc.* v. *Colorado Dep't of Social Servs.*, 879 F.2d 789, 796 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990) (applying *de novo* review to determine if the State has "identif[ied] and determine[d]: 1) efficiently and economically operated

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2/(...continued)
adequate," while engaging in "plenary review" of "reasonable access" and "proportionate share" requirements. *West Virginia Univ. Hosps., Inc.* v. *Casey*, 885 F.2d 11, 24 (3d Cir. 1989), *aff'd on other grounds*, 499 U.S. 83 (1991). The Tenth Circuit's decision in *Amisub*, which was cited by the Court in *Wilder*, in fact engaged in *de novo* review of both procedural and substantive compliance with Boren Amendment. See *Amisub (PSL), Inc.* v. *Colorado Dep't of Social Servs.*, 879 F.2d 789, 795-96 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990).

hospitals; 2) the costs that must be incurred by such hospitals; and 3) payment rates which are reasonable and adequate to meet the reasonable costs of the state's efficiently and economically operated hospitals").

Moreover, the court recognized that its articulation of the standard of review was in apparent conflict with a decision of the Seventh Circuit applying an arbitrary and capricious standard of review. App., *infra*, 19a, citing *Illinois Health Care Ass'n* v. *Bradley*, 983 F.2d 1460 (7th Cir. 1993), for the proposition that "procedural compliance with the findings and assurance requirement" is reviewed "under the arbitrary and capricious standard."

The court of appeals' decision warrants further review to clarify the standard of review that applies under the Boren Amendment, and to correct an erroneous application of a *de novo* standard of review that will disrupt the States' administration of the Medicaid program and destroy the flexibility that Congress intended to confer on the States by enacting the Boren Amendment.

C. *The Court of Appeals' Decision Is Contrary to the Principle That Courts May Not Impose Procedural Requirements on Agencies.*

This Court has recognized that judges should not "engraft[] their own notions of proper procedures upon agencies entrusted with substantive functions by Congress." *Vermont Yankee Nuclear Power Corp.* v. *Natural Resources Defense Council*, 435 U.S. 519, 541 (1978). In *Vermont Yankee*, the Court unanimously reversed a decision that "struck down [a] rule because of the perceived inadequacies of the procedures employed in the rulemaking proceedings." *Id.* at 541. The Court expressly stated that this principle applies in non-APA cases such as this one. *Id.* at 524. The

Court concluded that "[a]bsent constitutional constraints or extremely compelling circumstances the 'administrative agencies "should be free to fashion their own rules of procedure and to pursue methods of inquiry capable of permitting them to discharge their multitudinous duties."'" 435 U.S. at 543 (quoting *FCC* v. *Schreiber*, 381 U.S. 279, 290 (1965), quoting, in turn, *FCC* v. *Pottsville Broadcasting Co.*, 309 U.S. 134, 143 (1940)). See also *PBGC* v. *LTV Corp.*, 496 U.S. 633, 654 (1990) ("*Vermont Yankee* stands for the general proposition that courts are not free to impose upon agencies specific procedural requirements that have no basis in [a statute]").

That principle applies with particular force in this case. Medicaid is a "cooperative federal-state program," *Wilder*, 496 U.S. at 502, and federal courts should be especially reluctant to impose procedural requirements on state agencies. Furthermore, Congress enacted the Boren Amendment with the intention "that the primary responsibility for developing rates be transferred to the States," *id.* at 516, and that the States not be "overburden[ed] . . . with unnecessary and burdensome paperwork requirements," *id.* (quoting S. Rep. No. 139, 97th Cong., 1st Sess. 478 (1981). The federal courts certainly should not inject themselves into a role that Congress expressly transferred from the Secretary of HHS to the States.

The court's decision not only conflicts with *Vermont Yankee*, but also is in apparent conflict with the Ninth Circuit's decision in *Folden*, which recognized that "states are free to create their own methods of arriving at the required findings and . . . the finding process does not require any special studies or written findings." 981 F.2d at 1057. As a practical matter, the court of appeals' decision may require the State to provide a written statement of reasons for its action. This Court has held that even the APA does not require such

a statement of reasons for informal agency action. See *Camp* v. *Pitts*, 411 U.S. 138 (1973); *Citizens to Preserve Overton Park, Inc.* v. *Volpe*, 401 U.S. 402, 417-21 (1971).

II. THE COURT SHOULD RECONSIDER ITS DECISION IN *WILDER*.

This case presents an appropriate opportunity for the Court to reconsider its decision in *Wilder* that health care providers can enforce the provisions of the Boren Amendment through an action under 42 U.S.C. § 1983. *Wilder*, like a recent constitutional precedent overruled by this Court in *Payne* v. *Tennessee*, was "decided by the narrowest of margins, over [a] spirited dissent[] challenging the basic underpinnings of [the] decision[]." *Payne* v. *Tennessee*, 111 S. Ct. 2597, 2611 (1991). To be sure, the doctrine of *stare decisis* weighs against overruling a judicial decision, particularly in a statutory case. See, *e.g.*, *Patterson* v. *McLean Credit Union*, 491 U.S. 164, 172-73 (1989); *Square D Co.* v. *Niagara Frontier Tariff Bureau, Inc.*, 476 U.S. 409, 424 (1986). But the doctrine of *stare decisis* is not an "inexorable command." *Payne*, 111 S. Ct. at 2609; *Burnet* v. *Coronado Oil & Gas Co.*, 285 U.S. 393, 405-11 (Brandeis, J., dissenting). Other factors may outweigh the policy of *stare decisis*, as demonstrated by the numerous decisions of this Court overruling statutory precedents.[8/]

[8/] See, *e.g.*, *Monell* v. *Department of Social Servs.*, 436 U.S. 658 (1978) (overruling *Monroe* v. *Pape*, 365 U.S. 167 (1961)); *Continental T.V., Inc.* v. *GTE Sylvania Inc.*, 433 U.S. 36 (1977) (overruling *United States* v. *Arnold, Schwinn & Co.*, 388 U.S. 365 (1967)); *Lodge 76, International Ass'n of Machinists* v. *Wisconsin Employment Relations Comm'n*, 427 U.S. 132 (1976) (overruling *International Union, U.A.W.A.* v. *Wisconsin Employment Relations Bd.*, 336 U.S. 245 (1949)); *Braden* v. *30th Judicial Circuit Court*, 410 U.S. 484 (1973) (overruling *Ahrens* v. *Clark*, 335 U.S.

(continued...)

"In cases where statutory precedents have been overruled, the primary reason for the Court's shift in position has been the intervening development of the law." *Patterson*, 491 U.S. at 173. "Where such changes have removed or weakened the conceptual underpinnings from the prior decision, . . . the Court has not hesitated to overrule an earlier decision." *Id.* (citations omitted). That factor justifies reconsideration of *Wilder*. The Court's recent decision in *Suter* v. *Artist M*, 112 S. Ct. 1360 (1992) has removed the conceptual underpinnings from *Wilder*.

In *Suter*, the Court held that the "reasonable efforts" clause of the Adoption Assistance and Child Welfare Act of 1980, 94 Stat. 500, 42 U.S.C. § 671(a)(15), is not enforceable through an action under 42 U.S.C. § 1983. The Court's opinion in *Suter* did not adhere to the three-part analysis employed in *Wilder* (*i.e.*, whether the statutory provision was intended to benefit the plaintiff, whether it reflects a congressional preference rather than a binding obligation on the governmental unit, and whether the interest asserted by the plaintiff is so vague as to be beyond the competence of the judiciary to enforce). Instead, the Court, relying on *Pennhurst State School & Hospital* v. *Halderman*, 451 U.S. 1, 17 (1981), concluded that the statutory language at issue did not "unambiguously confer an enforceable right upon the Act's beneficiaries," because it is "at least as plausibly read to impose only a rather generalized duty on the State, to be enforced not by private individuals, but by the Secretary."

[8/](...continued)
188 (1948)); *Andrews* v. *Louisville & N.R.R. Co.*, 406 U.S. 320 (1972) (overruling *Moore* v. *Illinois Central R.R.*, 312 U.S. 630 (1941)); *Boys Markets, Inc.* v. *Retail Clerks Union, Local 770*, 398 U.S. 235 (1970) (overruling *Sinclair Refining Co.* v. *Atkinson*, 370 U.S. 195 (1962)); *Peyton* v. *Rowe*, 391 U.S. 54 (1968) (overruling *McNally* v. *Hill*, 293 U.S. 131 (1934)).

112 S. Ct. at 1370. The Court further departed from its analysis in *Wilder* by relying in part on the availability of other enforcement mechanisms, even though they were not sufficiently comprehensive to manifest Congress' intent to foreclose remedies under § 1983. Compare 496 U.S. at 520-23 with 112 S. Ct. at 1368-69. The Court's decision in *Suter* thus removes the conceptual underpinnings from *Wilder*. See *Arkansas Medical Soc'y, Inc.* v. *Reynolds*, 6 F.3d 519, 524 (8th Cir. 1993) (In *Suter*, "the Court did not proceed analytically as it had in recent precedents").

This Court has also overruled statutory precedents "because of inherent confusion created by an unworkable decision." *Patterson*, 491 U.S. at 173 (citations omitted). That has certainly been the case with the *Wilder* decision. Judicial experience since *Wilder* has shown that the extremely broad and vague terms of the Boren Amendment cannot be effectively enforced by the courts. The Boren Amendment refers to rates that are "reasonable" and "adequate" to cover the costs that "must be incurred by efficiently and economically operated facilities," but the Secretary has expressly declined to define these open-ended terms by regulation, and the courts have been unable to fill the "definitional abyss." See 48 Fed. Reg. 56047-56049; *Lett* v. *Magnant*, 965 F.2d 251, 253 (7th Cir. 1992).[9/] The courts

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[9/] See, *e.g.*, *Pinnacle Nursing Home* v. *Axelrod*, 928 F.2d 1307 (2d Cir. 1991); *Temple Univ.* v. *White*, 941 F.2d 201 (3d Cir. 1991), *cert. denied*, 112 S. Ct. 873 (1992); *West Virginia Univ. Hosp., Inc.* v. *Casey*, 885 F.2d 11, 24 (3d Cir. 1989); *Mississippi Hosp. Ass'n, Inc.* v. *Heckler*, 701 F.2d 511 (1983); *Illinois Health Care Ass'n* v. *Bradley*, 983 F.2d 1460 (7th Cir. 1993); *Lett* v. *Magnant*, 965 F.2d 251, 253 (7th Cir. 1992); *Wisconsin Hosp. Ass'n* v. *Reivitz*, 733 F.2d 1226 (7th Cir. 1984); *Nebraska Health Care Ass'n* v. *Dunning*, 778 F 2d 1291 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987); *Folden* v. *Washington State Dep't of Social & Health*

(continued...)

have adopted varying positions on the standard of judicial review (*e.g.*, compare the decision below with *Illinois Health Care*), on the scope of the procedural and substantive requirements of the Boren Amendment (*e.g.*, compare the decision below with *Folden*), on the requirements for making valid findings (*e.g.*, compare the 3-step procedure required by the Tenth Circuit in *Amisub*, which was explicitly not required by the Seventh Circuit in *Illinois Health Care*), and even on whether Boren Amendment "findings" need to be supported by written studies (*e.g.*, compare *Illinois Health Care* with *Folden*).

Moreover, judicial enforcement of the Boren Amendment has enmeshed lower federal courts in the minutiae of Medicaid rate-making activities, an area where they have little if any expertise. The Fifth Circuit's consideration in this case of such issues as whether the State considered an appropriately "scientific" sample of hospitals when analyzing hospital costs, or whether the State looked at labor costs as opposed to total costs, or whether "case mix changes" had been evaluated, is not atypical of judicial decisions under the Boren Amendment. App., *infra*, 21a-22a. Some district courts have seemingly examined virtually every detail of a State's ratemaking system, *e.g.*, *Multicare Medical Center* v. *Washington*, 768 F. Supp 1349 (D. Wash. 1991), and courts of appeals have at times behaved in a similar fashion. *E.g.*, *Illinois Health Care*, 983 F.2d at 1466 (reviewing the State's estimate of the number of minutes that it takes to feed a nursing home patient).

[2/](...continued)
Servs., 981 F.2d 1054 (9th Cir. 1992); *Amisub (PSL)* v. *Colorado Dep't of Social Servs.*, 879 F.2d 789 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990); *Colorado Health Care Ass'n* v. *Colorado Dep't of Social Servs.*, 842 F.2d 1158 (10th Cir. 1988); *Mary Washington Hosp., Inc.* v. *Fisher*, 635 F. Supp. 891 (E.D. Va. 1985); *Anco, Inc.* v. *State Health & Human Serv. Finance Comm'n*, 388 S.E.2d 780 (S.C. 1989).

The practical problems that Boren Amendment lawsuits present for States do not end with the ambiguity of the statute and the uncertainty in predicting what a reviewing court will do. The lawsuits tend to be expensive and complex, frequently result in burdensome discovery of the state officials' rate-making activities, often lead to the retention of outside consultants and experts, and otherwise complicate the State's administration of a highly complex and important welfare program. So far as the program recipients are concerned, a State's efforts to defend the lawsuits are of no benefit, nor is there an evident benefit for the recipients in judicial insistence on detailed and expensive "findings processes." The waste of resources is particularly evident in cases such as this one, where the issue being litigated is not whether the rates in fact are adequate to provide the level of compensation required by the statute but only whether the State has complied with a technical procedural requirement.

In sum, in light of the difficulties courts have experienced in applying the vague terms of the Boren Amendment, and the tension between *Wilder* and *Suter*, the Court should reconsider whether the Boren Amendment is enforceable through an action under 42 U.S.C. § 1983.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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February 24, 1994

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 92-3995.

ABBEVILLE GENERAL HOSPITAL,
et al., Plaintiffs-Appellants,

v.

David L. RAMSEY, Secretary, Department
of Heath and Hospitals, et al.,
Defendants-Appellees.

Appeal from the United States District Court for the Middle District of Louisiana.

Sept. 22, 1993.
As Remanded on Denial of Rehearing
Nov. 26, 1993

Before EMILIO M. GARZA and DeMOSS, Circuit Judges and Zagel[1], District Judge.

ZAGEL, District Judge.

A penny saved is a penny earned. That is the formula for federal Medicaid law — hospitals that save dollars by operating efficiently and economically earn state and federal dollars to cover all operating costs. The Medicaid Act,[2] specifically the Boren Amendment, provides that hospitals in participating states that operate "efficiently and economically" are entitled to reimbursement of costs which must be incurred. 42 U.S. § 1396a(a)(13)(A)(1991). Louisiana's Medicaid plan adopts the same formula since Louisiana elected to participate in the joint federal-state Medicaid program and receive matching federal funds. Louisiana's Department of Health and Hospitals ("LDHH"), under the direction of its secretary, administers its Medicaid plan.

As a participating state, Louisiana must comply with the Medicaid Act and implementing regulations promulgated by the Health Care Financing Administration (HCFA). *Amisub, (PSL), Inc.* v. *Colorado Dep't of Social Servs.*, 879 F.2d 789, 794 (10th Cir. 1989), *cert. denied*, 496 U.S. 935, 110 S.Ct. 3212, 110 L.Ed.2d 660 (1990). The federal structure gives each state Medicare agency a certain degree of flexibility in developing its Medicaid plan. Each plan, however, must provide for the reimbursement of inpatient hospital services:

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[1] District Judge of the Northern District of Illinois, sitting by designation.

[2] Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, is commonly referred to as the Medicaid Act.

> through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and federal laws, regulations and quality and safety standards.

42 U.S.C. § 1396a(a)(13)(A). In fact, the Supreme Court in *Wilder* v. *Virginia Hosp. Assoc.*, 496 U.S. 498, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990), held that the leeway in adopting a method of computing rates does not relieve States of their obligation to pay reasonable rates. *Id.* at 2520. Once developed, each state must submit its plan to HCFA for approval. 42 U.S.C. § 1396. To secure HCFA approval, each state Medicare Agency must make findings and submit assurances to HCFA that: (1) the payment rates "are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers"; (2) the methods and standards employed "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs"; and (3) the payment rates "are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality." 42 C.F.R. § 447.253(b)(1)(i), (ii)(A), (ii)(C) (1992). Such findings must be made and assurances filed with every amendment to established plans; findings must be made at least annually. 42 C.F.R. § 447.253(a), (b) (1992).

LDHH first developed its Medicaid plan for inpatient hospital services in 1983. Under the plan, LDHH reimburses hospitals 100 percent of all capital costs, educational expenses, and malpractice expenses. The remaining operating costs are

reimbursed either on a 100 percent basis or at a maximum level predetermined by each hospital's "target rate." LDHH set each hospital's initial "target rate" as the higher of its 1980 and 1981 average operating costs per Medicaid discharge. The plan allowed LDHH to increase these target rates in 1982, 1983, and 1984 in accordance with HCFA's inflation index published periodically. In 1985 and 1986, LDHH submitted proposed amendments to freeze the target rates for cost reporting periods beginning July 1, 1985 through June 30, 1987. HCFA approved this freeze. In 1987, LDHH resumed its plan and increased target rates up to 2.3% under the HCFA index. In 1988, LDHH again froze target rates until July 1, 1990, despite HCFA's disapproval of the proposed amendment.[3] Since then, target rates have increased annually by the amount of the applicable HCFA indices.

The dispute in Louisiana concerns whether LDHH made findings and submitted assurances as required by the Boren Amendment. The Hospitals[4] here complain that LDHH did not apply the "penny saved, penny earned" formula outlined in the Medicaid Act in deriving the reimbursement rates set under Louisiana's initial Medicaid plan and amendments for the years 1985, 1986, 1988, 1989 and 1990. The Hospitals

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[3] HCFA rejected LDHH's assurances and disapproved the 1988 amendment, stating that LDHH failed to "provide any information or data that demonstrates any relationship between [the 60 percent of the] facilities [being reimbursed their costs] and efficiency and economy . . . . [and] failed to substantiate its contention that its rates take into account economic conditions that will occur during the rate year." (Letter dated December 20, 1989 from Louis B. Hays, HCFA Acting Administrator, to Carolyn O. Maggio, LDHH Director.)

[4] Fifty-eight Louisiana hospitals ("Hospitals") joined to file this federal suit.

filed a § 1983 action against the Secretary of LDHH and other agency officials, claiming their actions deprived them of rights secured under the Boren Amendment. The Hospitals eventually moved for partial summary judgment declaring that LDHH failed, as a matter of law, to comply with the Boren Amendment when it established reimbursement rates and other payment schedules under Louisiana's Medicaid plan. In the motion, the Hospitals challenged LDHH's assurances submitted to HCFA, insisting that LDHH failed to make any "findings" that the rates set were reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated hospitals.

LDHH followed suit and filed a cross motion for partial summary judgment declaring that it complied with the findings process mandated in the Medicaid Act and its regulations. The district judge granted LDHH's motion for partial summary judgment, concomitantly denied the Hospitals' motion for summary judgment, dismissed the case in its entirety, and subsequently denied the Hospital's motion for a new trial, but amended his prior ruling.[5] The Hospitals now appeal. This Court has jurisdiction to hear their appeal under 28 U.S.C. § 1291.

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[5] In their motion for new trial, the Hospitals assigned error to the district court's dismissal of their claims challenging the substantive adequacy of the rates not raised in the cross motions for summary judgment. The district judge denied the motion without addressing the issue. Rather, in the October 26, 1992 ruling, Judge Polozola stated:

> The Court deletes from its first opinion the reference that the HCFA had approved the 1988 "freeze" amendment. This is a clerical error on the Court's part and has no bearing on the Court's final decision. As noted in the first opinion, the approval by the HCFA is not binding on the Court, but is evidence which may be considered by the Court.

On appeal, the Hospitals seek review of the district court's grant of summary judgment and other adverse rulings. The Hospitals maintain that the district court erred when it: (1) applied the highly deferential "arbitrary and capricious" standard of judicial review to the procedural issue of whether the LDHH complied with federal law; (2) determined that, as a matter of law, LDHH complied with the Boren Amendment and was entitled to summary judgment; and (3) dismissed the entire case, including the substantive issues on the reasonableness and adequacy of the reimbursement rates, after ruling only on the preliminary issue of procedural compliance with the Boren Amendment.

STANDARD OF REVIEW

We review a district court's grant of summary judgment *de novo*, employing the same standard as a district court would employ under Federal Rule of Civil Procedure 56(c). *Harbor Ins. Co.* v. *Urban Constr. Co.*, 990 F.2d 195, 199 (5th Cir. 1993). Summary judgment is proper only if no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Anderson* v. *Liberty Lobby, Inc.*, 477 U.S. 242, 250, 106 S.Ct. 2505, 2511, 91 L.Ed.2d 202 (1986). All reasonable inferences are drawn in favor of the nonmoving party. *Harbor*, 990 F.2d at 199. The parties here do not dispute the material facts. They argue whether the facts of record support a judgment as a matter of law that LDHH made appropriate findings and assurances in compliance with the Boren Amendment. LDHH says "yes"; the Hospitals say "no."

> Both parties concede that summary judgment was sought only on LDHH's procedural compliance with the Boren Amendment. LDHH argues that summary judgment, declaring LDHH had made valid findings,

automatically forecloses the Hospitals' challenge to the substantive adequacy of the rates set. *See infra* note 11, discussing propriety of district court's dismissal of case in its entirety. Still remaining unaddressed at trial are the Hospitals' claims related to outpatient services (subject of undecided motion to dismiss) and to the state plan's failure to provide adequate methods of accounting for changes in cases mix.

LDHH has made its findings and submitted assurances to HCFA for approval of its initial Medicaid plan in 1984 and all subsequent amendments to the plan's reimbursement rates. HCFA approved the plan and amendments to "freeze" reimbursement rates until 1988. LDHH contends that this federal agency action entitles Louisiana's plan to a presumption of regularity and warrants application of the arbitrary and capricious standard for reviewing the record to determine whether LDHH complied with federal law. LDHH cites a litany of cases for the indisputable proposition that a state agency's rate-setting action is entitled to considerable deference and is reviewable only under the arbitrary and capricious standard.[6] But this rule does not resolve the specific question presented here.

There is a fundamental difference under the Medicaid Act between an agency's discretion to set reimbursement rates and an agency's mandatory compliance with the findings and assurances requirements. It is LDHH's compliance or

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[6] *See, e.g., Let* v. *Magnant*, 965 F.2d 251, 257 (7th Cir. 1992) (plaintiff must establish "that the plan is either arbitrary and unreasonable or inadequate" and agency's actions are presumptively valid); *West Virginia Univer. Hosps., Inc.* v. *Casey*, 885 F.2d 11, 23-24 (3rd Cir. 1989) (court must apply "deferential standard of review in assessing compliance with the [Boren Amendment's] 'reasonable and adequate' requirement").

noncompliance with the findings requirement that is subject to cross motions for partial summary judgment. The findings requirement is both a procedural and a substantive requirement — LDHH must find that the rates are reasonable and adequate and the plan must adopt rates that are actually reasonable and adequate. *Wilder*, 496 U.S. at 512, 110 S.Ct. at 2519; *Illinois Heath Care Assoc.* v. *Bradley*, 983 F.2d 1460, 1463 (7th Cir. 1993) (distinguishing between the Boren Amendment's procedural component that the agency make findings and assurances and its substantive component that the plan implemented result in adequate payments). The Hospitals complained below of LDHH's noncompliance in practice with the findings requirement and the plan's noncompliance with the substantive findings requirement. 42 C.F.R. § 430.35(C) (1992) ("A question of noncompliance in practice may arise from the State's failure to actually comply with a Federal requirement, regardless of whether the plan itself complies with that requirement.")).

What standard does a federal court use to determine whether LDHH complied with the procedural requirements of federal law, i.e., whether LDHH, in fact, made the "findings" stipulated in the Boren Amendment? Whether LDHH complied with the procedural requirements of the Boren Amendment is a question of law, subject to *de novo* review. *Amisub*, 879 F.2d at 795. On this point most opinions are clear.[7] By conducting such a review of the agency's actions,

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[7] *But see Illinois Health Care*, 983 F.2d at 1462-63 (reviewing IDPA's procedural compliance with the findings and assurances requirement under the arbitrary and capricious standard). The Seventh Circuit states as its reason for deferential treatment of this issue that the Secretary's approval of the reimbursement plan renders the plan a "product of state and federal agency action." This reasoning, however, does not apply when the state makes findings. The Secretary does not participate in the agency's findings process. The Secretary's role is confined to

federal courts do not usurp the agency's permissible authority to balance political and financial interests underlying the Medicaid plan.

The opinions are not so clear on the proper standard for reviewing substantive compliance with the findings requirement.[8] The opinions generally recite the boiler plate language — *de novo* review of procedural and substantive compliance with federal law and arbitrary and capricious review of nonadjudicatory agency actions. Some opinions then proceed, we think, to conflate the issues reviewable for

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reviewing the reasonableness of the state's assurances. *Wilder*, 496 U.S. at 507-08, 110 S.Ct. at 2516-17. The Secretary neither reviews the methodology for reimbursement nor scrutinizes the underlying findings. *Id.* LDHH's findings, therefore, are not the product of state and federal agency action.

LDHH concedes in its brief that "conceivably a *de novo* standard might be appropriate" where no findings are made. Once *bona fide* findings are made, however, LDHH's expertise and the Secretary's approval warrant the same degree of deference to the rate-setting decision as accorded a federal agency. The court in *Illinois Health Care* recognized that determining the median cost of operating nursing homes that retain a basic level of care and pass inspection is a matter "for the state to solve by combining its economic expertise with its practical knowledge." 983 F.2d at 1465. But this expertise did not excuse the state agency's obligation to make findings which establish a nexus between the cost and the proposed reimbursement rates.

[8] In *Mississippi Hosp. Assoc., Inc.* v. *Heckler*, 701 F.2d 511 (5th Cir. 1983), we recognized this bedlam and "assum[ed] without deciding that by force of statutory or constitutional requirements, a district court is entitled to review the actions of a state agency administering federal Medicaid funding as it would review the actions of a federal agency." *Id.* at 516. We then proceeded, without further discussion, to determine whether both the plan's rates and the state Medicaid agency's findings were irrational and the product of arbitrary and capricious decision-making. *Id.* at 516-519.

substantive compliance with the Boren Amendment with issues reviewable as otherwise nonadjudicatory agency action.[9] Both involve a review of the underlying factual foundation and a substantive determination regarding the adequacy of the payment rates. Both implicate a balancing of policy and financial considerations. Both fall within the auspices of the state agency's exercise of discretion. Finally, both are reviewed to some degree by the Secretary prior to approving a plan or amendment. *See Illinois Health Care*, 983 F.2d at 1465 ("rate-setting and the identification of efficiently and economically operated facilities are all part of the same process") (quoting *Folden v. Washington State Dep't of Social*

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[9] The court in *Amisub* reviewed *de novo* whether the evidence was sufficient to support the "finding" and assurances that efficient and economical hospitals are reasonably and adequately compensated. 879 F.2d at 797-799. The opinion focused on (1) the expert testimony that no hospital, no matter how efficient, would be reimbursed for actual costs and (2) the program director's testimony that the assurances rested solely on the historical trend concept, i.e., the new system is adequate because it pays the same as the old system, which was adequate. The Tenth Circuit said that "[s]ince we find no evidence admitted at trial to support appellee's 'assurances' on appeal, and find overwhelming evidence to the contrary, we hold that the Colorado Medicaid Plan, effective July 1, 1988, is violative of the substantive provisions of federal Medicaid law." *Id.* at 799.

After this holding, the Tenth Circuit reviewed the record to determine whether the state agency's findings and assurances were reasonably related to a factual foundation or whether they were arbitrary and capricious. *Id.* at 799-801. Here, the court confined its review to whether the factors considered were relevant. The court then found that the "record is blatantly devoid of any effort ... to make the federally mandated findings" where the assurances are based solely on budgetary constraints. *Id.* at 800. The court ultimately remanded the case and ordered the state agency "to comply with the procedural and substantive requirements of the federal Medicaid Act and its implementing regulations, and to engage in a *bona fide* findings process before submitting any new plan and/or assurances to HCFA." *Id.* at 801.

& Health Servs., 744 F.Supp. 1507, 1533 (W.D. Wash. 1990)).

It is precisely the agency's exercise of discretion and the Secretary's approval that warrant application of the arbitrary and capricious standard of review. *Illinois Health Care*, 983 F.2d at 1462-63 (reimbursement plan, approved by Secretary and product of federal-state agency action, must be reviewed with the same deference accorded federal agency actions); *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306, 1313 (2d Cir. 1991). The reason for the policy of deferential review of a federal agency's interpretation of federal law is its "expertise and familiarity ... with subject matter of its mandate and the need for coherent and uniform construction of federal law nationwide." *Turner v. Perales*, 869 F.2d 140 (2d Cir. 1989). The joint federal-state Medicaid program and the rate-setting flexibility mandated by the Boren Amendment evoke the same policy. This two-step review process — *de novo* review of the state's factfinding process and arbitrary and capricious review of the findings and rates — provides the "minimum necessary to assure proper accountability." S. Rep. No. 139, 97th Cong., 1st Sess. 478 (1981), *reprinted in* 1981 U.S. Code Cong. & Admin. News 396, 744.[10] It also strikes a

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[10] In holding that the Boren Amendment creates a right enforceable under § 1983, the Supreme Court anticipated the debate over standards of review in this area. It stated, "That the Amendment gives the States substantial discretion in choosing among reasonable methods of calculating rates may affect the standard under which a court reviews whether the rates comply with the Amendment, but it does not render the Amendment unenforceable by a court." *Wilder*, 496 U.S. at 520, 110 S.Ct. at 2523. *Wilder* did not decide what standard a court should use to review a state agency's actions under the Boren Amendment. The Court, however, did acknowledge that the Secretary has "limited oversight" over the plans. Also, in holding that § 1983 allows for private enforcement of the Boren Amendment, the Court rejected the petitioners' argument that Congress gave the Secretary, not the federal court, power to ensure that the rates are

balance between Congress's view of the federal role under the Medicaid Act and general principles of federalism, which do not permit states to be final arbiters of their compliance with federal law. Accordingly, a presumption of regularity and deferential standard attaches to LDHH's exercise of discretion in setting reimbursement rates, but only after a reviewing court determines that LDHH made *bona fide* findings.

The first question then is whether LDHH made findings in compliance with the Boren Amendment procedural requirements. If yes, then and only then will we need to inquire into the substantive adequacy and reasonableness of these reimbursement rates using the arbitrary and capricious standard of review. *Wilder*, 496 U.S. at 520 n. 18, 110 S.Ct. at 2523 n. 18; *Nebraska Health Care Assoc.* v. *Dunning*, 778 F.2d 1291, 1294 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063, 107 S.Ct. 947, 93 L.Ed.2d 996 (1987). Even this standard and the presumption of validity do not shield LDHH from a "thorough, probing, in-depth review" of the Medicaid plan. *Illinois Health Care*, 983 F.2d at 1463 (quoting *Citizens to Preserve Overton Park, Inc.* v. *Volpe*, 401 U.S. 402, 415, 91 S.Ct. 814, 823, 28 L.Ed.2d 136 (1971) (reviewing under

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not based on false findings. *Id.* at 496 U.S. at 515, 110 S.Ct. at 2520. The Court's decision in *Wilder* suggests that Congress intended federal courts to give deference to a state's reimbursement rate determinations unless the assurances submitted are based on patently false findings. The Hospitals here contend any other result would render LDHH's duty to make findings a mere formality, and LDHH's duty to make appropriate findings under the Boren Amendment was not intended by Congress to be a mere formality. *Id.* at 515, 110 S.Ct. at 2520.

arbitrary and capricious standard the Secretary's approval of highway construction through park)).[11]

LDHH'S FINDINGS

The Hospitals contend the LDHH never engaged in a findings process to substantiate its compliance with the Boren Amendment and its implementing regulations. In their view, LDHH first erred by not adopting an objective profile of what constitutes an economically and efficiently operated hospital and, instead, arbitrarily defined an economic and efficient hospital as one whose costs do not exceed the assigned target rate. Second, LDHH improperly relied on "subjective, generalized and unsupported assumptions about the general state of the economy in Louisiana" in deviating from the state Medicaid plan and imposing target rate "freezes." Third, LDHH violated federal law because it implemented and continued the rate freezes in 1989 and 1990, after HCFA disapproved the TN 88-12 proposed freeze, and because LDHH did not submit assurances to HCFA for the years 1989 and 1990. LDHH responds that it made the appropriate findings and points to the affidavits of Carolyn O. Maggio (director of LDHH Bureau of Health Services Financing) and

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[11] The Hospitals also assign error to the district court's dismissal of the entire case, including the substantive issues on the reasonableness and adequacy of the reimbursement rates. This Court agrees that there was error in dismissing the substantive claims. The summary judgment motions pertained solely to the issue of procedural compliance with federal law. While procedural noncompliance renders futile any attempted substantive compliance, procedural compliance does not guarantee compliance with substantive federal law. *See Mississippi Hosp. Assoc., Inc.* v. *Heckler*, 701 F.2d 511 (5th Cir. 1983) (reviewing separately whether the state agency complied with the procedural requirements and whether the reimbursement rates were adequate in compliance with the substantive requirements of the Boren Amendment).

LDHH employee Helene Robinson (policy and program manager of Louisiana Medical Assistance Program).

Courts generally agree that a state can develop its own methodology for arriving at the required findings. *Amisub*, 879 F.2d at 797; *Illinois Health Care*, 983 F.2d at 1464. Regardless of the methodology, an agency still must make the required findings.[12] What constitutes a Medicaid Act "finding" has been defined in different ways in the last decades. Some opinions suggest that a finding simply consists

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[12] Federal regulations provide:

> (b) *Findings*. Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:
>
> > (1) *Payment Rates*. (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.
> >
> > (ii) With respect to inpatient hospital services —
> >
> > > (A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs;
> > >
> > > . . . .
> > >
> > > (C) The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

42 C.F.R. § 447.253(b) (1992).

of a "reasonably principled analysis." *Folden*, 744 F.Supp. at 1532. Others, ostensibly in the spirit of the Boren Amendment's flexible rate-setting scheme, pose that a finding is any showing of a "nexus" between reimbursement rates and efficiently and economically operated hospitals. *Pinnacle Nursing Home*, 928 F.2d at 1314. The most detailed definition of a finding appears in *Amisub*.

> [T]he plain language of federal Medicaid law mandates the State Medicaid Agency, *at a minimum*, to make "findings" which identify and determine 1) efficiently and economically operated hospitals; 2) the costs that must be incurred by such hospitals; and 3) payment rates which are reasonable and adequate to meet the reasonable costs of the state's efficiently and economically operated hospitals.

Amisub, 879 F.2d at 796 (emphasis in original).

Whether a court chooses to require a "reasonably principled analysis" or a "nexus" or a profile of efficiently and economically operated hospitals is not crucial to determining compliance with the findings requirement. All three of these cases adopt their own terminology to answer the same question. That is, what is the minimum quantum of evidence that an agency must possess in its cognition to substantiate its assurances that the reimbursement rates in the Medicaid plan and any proposed amendments (1) reasonably and adequately meet the costs that must be incurred by efficiently and

economically operated hospitals,[13] (2) accommodate hospitals serving a disproportionate number of low income patients with special needs, and (3) adequately ensure that Medicaid recipients have reasonable access to inpatient hospital services of adequate quality. 42 C.F.R. § 447.253(b)(1)(i), (ii)(A), (ii)(C) (1992).

The evidence clearly need not consist of the state agency's own comprehensive study of all state hospitals. In *Illinois Health Care*, the Seventh Circuit aptly observed that a sample of nursing homes as "paradigms of efficiency" may be impossible, waste money better spent on patients, and lead to more controversy. *Illinois Health Care*, 983 F.2d at 1464-65. On the other hand, the findings requirement is not a mere formality that can be satisfied simply by having a state officer think a bit about hospital costs and then copy out the statutory language on a piece of paper, put the heading "assurances" on that piece of paper, and send it to HCFA. *Wilder*, 496 U.S. 515, 110 S.Ct. at 2520; *Amisub*, 879 F.2d at 797; *see Pinnacle Nursing Home*, 928 F.2d at 1313-14 (procedural requirements are not "mere surplusage" but restrict the state's flexibility in formulating its reimbursement plan). The state agency must show it conducted an objective analysis, evaluation, or some type of factfinding process to determine the effects of the rates on the level of care Medicaid patients receive. *Nebraska Health Care*, 778 F.2d at 1294. As part of the factfinding process, the state agency must "judge the reasonableness of its rates against the objective benchmark of an 'efficiently and economically operated facility' providing care in compliance with federal and state standards while at

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[13] Part and parcel of this requirement is that a state find that lower rates are imposed on hospitals providing inappropriate levels of care as mandated in 42 C.F.R. § 447.252(a)(3)(ii). *Mississippi Hosp. Assoc., Inc. v. Heckler*, 701 F.2d 511, 521-22 (5th Cir. 1983).

the same time ensuring 'reasonable access' to eligible participants." *Wilder*, 496 U.S. at 519, 110 S.Ct. at 2522. This objective benchmark can be a "relative rather than an absolute concept." *Illinois Health Care*, 983 F.2d at 1467. It also can be implicit in a rate-setting methodology. *Id.*

LDHH admits, with some hesitation, that it conducted no studies and made no efforts to determine which state hospitals are efficiently and economically run. Instead, LDHH functioned under the premise that every hospital was economically and efficiently operated in 1981 and used the available cost reports for that base year to calculate the target rates for each hospital. Whether a particular hospital remains efficient and economical is gauged by whether the hospital stays within the designated target rate. Hospitals that exceed the designated target rate are deemed not efficient or economical and are not reimbursed actual costs. Rather, the hospitals receive the maximum payment determined by their respective target rates.[14]

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[14] Helene Robinson is the policy and program manager of the Louisiana Medical Assistance Program primarily responsible for administering the Medicaid plan and assuring compliance with federal law. Robinson's deposition on this point is worth an excerpt:

> Pizza [Counsel for the Hospitals]: Now what I'm trying to find out is, was any kind of study or analysis done to determine that hospitals that met or didn't meet their target rate were, in fact, either economic or not economic or efficient or not efficient?
>
> Robinson: Other than the deeming [of economic and efficient based on the target rate] —
>
> Pizza: Yes.
>
> Robinson: — as a result of the State plan?

Pizza: Right.

Robinson: I'm not aware of any.

Pizza: Now your answer is limited to '82, or is that for the whole period that you've been involved in the program?

Robinson: We do ongoing analyses of adequacies of the rates.

Pizza: I understand that, but I'm talking about the previous question. Has any study or analysis been done, to your knowledge, since you've been at the department concerning what you just answered?

. . . .

Robinson: Analyses that hospitals were efficient and economic if they were within their target rate?

Pizza: Right.

Robinson: We did those types of analyses. I mean, if they were within their target rate, they were deemed efficient and economic, even though they might have had some continued inefficiencies.

Pizza: So then some analyses have been done at some time to determine which hospitals are, in fact, economically and efficiently operated?

Robinson: They were deemed efficiently and economically operated if they were within —

Pizza: I'm still having a problem communicating then. I think it's clear so far that up to some period of time no studies were done to determine whether or not hospitals which met or didn't meet their target rate were, in fact, economically and efficiently operated?

Robinson: I don't know of any studies.

Pizza: Okay. What I'm trying to find out, is your answer limited to a particular year or does it cover the whole period of time you've

Clearly, the method by which LDHH promulgated the initial target rates fails the Boren Amendment test. LDHH did not make any finding that its plan complied with the three substantive requirements outlined in 42 C.F.R. § 447.253(b). Other than the cost reports, LDHH gathered no information and conducted no empirical analysis to ascertain whether the target rates "reasonably and adequately" compensated efficient and economical hospitals and hospitals servicing a disproportionate number of low income patients. "Federal law is not satisfied if a state merely makes conceptual policy decisions. A policy predicated upon provincialism and self-interest, not upon findings of reasonableness and adequacy, is unacceptable." *West Virginia Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 30 (3rd Cir. 1989).

LDHH insists that it engaged in "ongoing analyses of adequacies of the rates."[15] According to Robinson, in

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been working in the Medicare program?

Robinson: I guess it would cover about the whole time.

. . . .

Pizza: But would you say that if you don't know of any such studies, then, in fact, there probably were no studies?

Robinson: To any knowledge, there aren't any.

[15] LDHH argues that it considered numerous factors and information prior to imposing rate freezes:

> [1] Detailed operating and capital cost data for each hospital, including the extent to which individual hospitals recovered all or most of their operating costs[;]
>
> [2] [t]he long-term and continuing decline in hospital occupancy rates[;]

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[3] [h]ospital staffing levels[;]

[4] [n]umbers of licensed hospital beds[;]

[5] [t]he relatively few complaints regarding hospital quality of care, and information regarding hospital quality of care and information about certification of facilities[;]

[6] [i]nformation concerning continued expansion of hospital facilities[;]

[7] [i]nformation concerning entry and exit from the Medicaid program by inpatient hospitals[;]

[8] [t]he availability of an administrative process for reviewing and adjusting upwards the target rates of individual hospitals[;]

[9] [t]he State Plan's many generous features such as (i) 100 percent reimbursement of capital costs, malpractice and education expenses (ii) no cap on costs included in a facility's base year "target rate" calculation regardless of whether or not efficient; and (iii) generous per diem reimbursement of certain specialized care units, including neo-natal, burn, psychiatric and drug abuse units[;]

[10] [d]ata regarding employment, income and other economic trends nationally, in the Gulf Region, and in Louisiana, including information regarding the relatively depressed character of Louisiana's economy[; and]

[11] [t]he need for cost containment incentives.

(Appellee's Brief at 23-24 (record cites omitted).) LDHH cites only to Helene Robinson's affidavit as proof that it considered these factors. In determining whether LDHH complied with the procedural requirements of the Boren Amendment, this Court is not concerned with the adequacy of these alleged "findings" but with LDHH's fact-gathering procedures. Helene Robinson's affidavit indicates that she limited her review to the hospital's audited cost reports and data "gathered from other agencies and the media" on the general state of the economy in Louisiana (i.e.,

deciding to freeze the target rates, she "looked at how costs had increased from the base period to the current audited period versus how the average target rate had increased in that same period of time. And that the increases in the target rate were greater than the actual increases in costs." The "costs" compared were the hospitals' total cost per discharge, without any separation of labor costs or other cost components. Robinson retrieved this cost data from audited cost reports available for the latest time period. There were hospitals whose data was not considered. She did not employ a random statistical sampling or scientific methodology to determine that the hospitals reviewed were representative. Rather, Robinson admits in her deposition that she didn't do an actual analysis but based the "process" on what she thought was right based on her experience. Robinson further says that no analysis was done to determine if the uncounted hospitals skewed the results until 1987 or 1988.

Robinson says she reviewed other data available from the "Department of Labor and Statistics" and other publications reflecting general economic conditions. Robinson recalls in deposition she "had difficulty obtaining data on Louisiana-specific" information. She did manage to review "like weekly things in the newspaper . . . things in magazines and so on regarding, you know, unemployment, drops in personal income, and so on for the State." However, this analyses could not be reproduced because it was an "ongoing process" not reduced "necessarily [to] a written bound copy of something."

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recession and high unemployment rate) as compared to the nation. Robinson's deposition testimony clarifies exactly what efforts she made on behalf of LDHH to satisfy the findings requirement.

Furthermore, Robinson neither recommended to her staff nor initiated any efforts to obtain information regarding the economic conditions in the State as they affect hospitals, hospital labor costs, or any other costs that would be reflected in the hospital cost reports. Nor did Robinson recall having access to or using any studies or data base concerning such economic conditions and cost of care, or medical care, throughout the State. Finally, Robinson did not investigate the effects of case mix changes on Louisiana providers, such as increased outpatient services and longer hospital stays for inpatient services. What she says is this:

> Pizza: [W]as any study done by DHH during the period 1982 through 1989 to determine whether or not those factors influenced inflation for hospitals in Louisiana? [Those factors enumerated were the "increase in the hiring of Rns as opposed to LPNs, the increasing complexity of patient treatments, the trend of treating more outpatients [,] . . . that wage rates for hospital employees had climbed higher than for other kinds of employees, and finally that insurance costs had climbed at a higher rate for hospitals than it had for other industries nationwide."]
>
> Robinson: Studies were done in regard to hospital cost increases that would have reflected some of those factors.
>
> Pizza: I know, but was a study done, though, looking at those factors themselves and their effect on hospitals in Louisiana, germaine just to those factors?

Robinson: We look at the factors in the aggregate.

Pizza: So your answer then is no particular study was done to look at those individual factors; is that right?

Robinson: As I stated, we look at the factors and the increases in costs in the aggregate.

Pizza: Okay. Now when you say you looked at them in the aggregate, what did you do to look at them in the aggregate?

Robinson: We review cost data —

Pizza: Cost reports?

Robinson: — from the cost reports.

Pizza: So you examine cost reports to see how that data affected hospitals; is that right?

Robinson: We examine cost data to review — to determine the adequacy of the rates.

LDHH's purported "ongoing analysis" suffers from the same faulty logic as its initial rate-setting scheme. Findings were not made, instead assumptions were made. It is circular for LDHH to set target rates under the assumption that all hospitals are efficiently and economically operated and then identify efficiently and economically operated facilities as those whose costs fall below their own reimbursement rate. Under these circumstances, a hospital's ability to keep costs

below the target rate is not a reflection of its efficiency or economy of operations. Even Robinson admits this fallacy in LDHH's rate-setting methodology. She testified at her deposition that "if [the hospitals] were within their target rate, they were deemed efficient and economic, even though they might have had some continued inefficiencies." She also acknowledges in her affidavit that each hospital's target rate initially included all allowable base year costs, without "limit[] or cap[] in any respect to remove inefficient, uneconomic or unnecessary costs." By enacting the Boren Amendment, Congress intended states to abandon such "reasonable cost" schemes that paid actual hospital costs, despite obvious disparities in efficiencies and economies, in favor of reimbursement systems that encourage hospital efficiency and cost containment. H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981)[16]; *Temple University* v. *White*, 941 F.2d 201, 207 (3rd Cir. 1991); *West Virginia Univ. Hosp.*, 885 F.2d at 23.

LDHH has reduced its findings process to a simple exercise of compilation and assumption, completely ignoring the Congressional mandate that state agencies consider relevant factors such as efficiency, economy, quality of care, and reasonable access. LDHH emphasizes that it has received relatively few complaints regarding hospital quality of care.

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[16] The House of Representatives Report states in pertinent part:

> In eliminating the current requirement that States pay hospitals on a Medicare "reasonable cost" basis for inpatient services under Medicaid, the Committee recognizes the inflationary nature of the current cost reimbursement system and intends to give States greater latitude in developing and implementing alternative reimbursement methodologies that **promote the efficient and economical delivery of such services.**

H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981) (emphasis added).

This fact, however, says nothing about the reasonableness or adequacy of rates to meet the needs of efficiently and economically operated hospitals where rates initially set assume that every hospital is efficient and economic. At most, LDHH's "findings" process consisted of reviewing general information regarding the state of the economy and the available cost reports. LDHH can point to nothing in the federal Medicaid scheme that permits it to use the general state of the economy as the sole justification for setting rates.[17] Nor is there anything that condones a findings procedure that employs only historical cost data and projected inflation figures. To the contrary, courts have condemned similar schemes.

In *Amisub*, the state Medicaid agency presented as evidence of its "findings" process only a "consistency between the current expenditure for Medicaid provider reimbursement and the amount of money historically appropriated by the Colorado legislature, and HCFA's acceptance of the previous Colorado Medicaid Plan." *Amisub*, 879 F.2d at 796. The Tenth Circuit rejected this evidence as proof of "findings" for three reasons. First, the state agency's reliance on HCFA's approval of a previous plan belies the statutory requirement that agency's make at least annual findings. *Id.* at 797.

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[17] In *Illinois Health Care* v. *Bradley*, 983 F.2d 1460 (7th Cir. 1993), the Seventh Circuit affirmed the district court's declaratory judgment invalidating Illinois's Medicaid plan for failure to make proper findings. The rates allegedly were premised on time and motion studies conducted in the early 1980s in other states. *Id.* at 1466. Skeptical that the unproduced studies ever existed, the court found that the plan did not implicitly identify the economic and efficient nursing homes in Illinois and, thus, did not comply with the Boren Amendment's procedural requirements. *Id.* at 1467. The court also determined that a finding that a rate is adequate and reasonable merely because a number of nursing homes are profitable does not constitute a "finding" in compliance with the Amendment. *Id.*

Second, there is nothing in the Medicaid Act from which to infer that an agency may rely solely on the "historical trends concept" that the new plan is adequate because the monetary appropriations are identical to the old plan. *Id.* at 797, 799. Finally, a "record is blatantly devoid of any effort . . . to make the federally mandated findings" where the assurances are based solely on budgetary constraints. *Id.* at 800. The Tenth Circuit ultimately remanded the case and ordered the state agency "to comply with the procedural and substantive requirements of the federal Medicaid Act and its implementing regulations, and to engage in a *bona fide* findings process before submitting any new plan and/or assurances to HCFA." *Id.* at 801.[18] We too remand this case and order LDHH to engage in a *bona fide* findings process.

LDHH likens its case to that in *Mississippi Hosp. Assoc., Inc.* v. *Heckler*, 701 F.2d 511 (5th Cir. 1983), where we affirmed summary judgment declaring that Mississippi's Medicaid agency complied with the federal procedural requirements. *Mississippi Hosp.*, however, is inapposite for two reasons. First, in *Mississippi Hosp.*, we did not review whether the state agency engaged in a *bona fide* findings process. Rather, Mississippi's Medicaid agency was accused

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[18] In *Temple University* v. *White*, 941 F.2d 201 (3rd Cir. 1991), the court invalidated the Medicaid plan for failure to make "critical and required findings." The state agency's review of its rate scheme was confined to internally-generated reports identifying hospitals with reported costs above and below the group rates and to some revenue projections. *Id.* at 210. The agency also noted that it received no complaints from Medicaid recipients regarding their ability to obtain care. *Id.* Both the district and appellate courts concluded that the state agency "made no findings as to the reasonableness or adequacy of its rates to cover costs of an efficiently and economically operated hospital or to account for the impact on a hospital of its across-the-board budget neutrality adjustment and varying percentage add-ons for disproportionate-share hospitals .... [or to ensure] reasonable access to inpatient hospital care." *Id.*

of not complying with federal procedural requirements based on its failure to consult with the Medicaid Care Advisory Committee, its publication of an allegedly inadequate public notice, and its failure to submit proper assurances. *Id.* at 520. It is evident from our discussion that Mississippi engaged in a *bona fide* findings process and that we confined our review to the sufficiency of these findings under the arbitrary and capricious standard. *Id.* at 516-18. We have not reached this second stage of analysis in this case.

Second, we find no similarities between the findings processes adopted by LDHH and those adopted by Mississippi's agency. Mississippi based its rate ceiling on two-years and over 300 hours of "careful and objective studies of cost data filed by Mississippi hospitals . . .[,] methods used by other states and the federal government . . .[,] an incredible rage of cost incurred by hospitals," and statewide occupancy rates. *Id.* at 517, 520. Here, Robinson's review of cost reports was limited to comparing the available aggregate costs to the hospital's target rate to determine reimbursement.

This Court cannot endorse such a *pro forma* compliance with the findings requirement of the Boren Amendment. LDHH's inability to articulate an orderly process of evaluation or to identify specific documents reviewed renders suspect its "findings" and renders meritless its argument that it engaged in a *bona fide* findings process. Because we find that LDHH, as a matter law, failed to comply in practice with the Boren Amendment findings requirement, this Court REVERSES the district court's grant of LDHH's summary judgment motion and denial of the Hospitals' summary judgment motion. This

case is REMANDED for proceedings not inconsistent with this opinion.[19]

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[19] We express no view on whether the Hospitals' summary judgment motion may be defeated, in part or in whole, by various affirmative defenses which were neither ruled on in the district court nor argued in this Court.

APPENDIX B

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

ABBEVILLE GENERAL HOSPITAL,
ET AL

CIVIL ACTION
NUMBER 91-356-B

VERSUS

DAVID L. RAMSEY, SECRETARY
DEPARTMENT OF HEALTH AND HOSPITALS,
ET AL

RULING ON CROSS MOTIONS FOR SUMMARY JUDGMENT

This matter is before the Court on cross motions for summary judgment. The Court also questioned whether it has subject matter jurisdiction in this case.[1]

The plaintiffs are various hospitals in Louisiana. They have filed this suit pursuant to 42 U.S.C. § 1983 against the Secretary of the Department of Health and Hospitals and other employees in the agency. Plaintiffs contend that the manner and method used by the defendants in implementing the State Medicaid Plan deprive plaintiffs of their rights secured under the Boren Amendment to the Medicaid Act, 42 U.S.C. §

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[1] The Court has considered all of the briefs filed by the parties and the arguments made by counsel at oral argument whether discussed in this opinion or not.

1396(a)(13)(A), and the United States Constitution. Plaintiffs seek both injunctive and declaratory relief.

Defendants contend they have made adequate findings and assurances required under the Boren Amendment. Defendants further contend that the Medicaid reimbursement rates paid to the hospital were sufficient to meet the costs that are incurred by efficiently and economically operated medical providers.

Although the Court still questions its jurisdiction, the Court is bound by the latest expression from the United States Supreme Court in *Wilder v. Virginia Hospital Ass'n.*, 496 U.S. 498, 110 S.Ct. 2510 (1990) which held that the federal court has subject matter jurisdiction in this case.[2] Therefore, the Court finds that it has subject matter jurisdiction in this suit.

Summary judgment is proper when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. (Rule) 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986); *Anderson v. Liberty Lobby*, 477 U.S. 242, 106 S. Ct 2505, 91 L. Ed. 2d 202 (1986); *Fontenot v. UpJohn Co.*, 780 F.2d 1190 (5th Cir. 1986). Although the initial burden of proof is on the moving party, if the documentation supports the motion, the burden shifts to the non-moving party. *Landry v. Air Line Pilots Assoc. Int'l. AFL-CIO*, 901 F.2d 404 (5th Cir. 1999). To

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[2] The Supreme Court held: "[T]he Boren Amendment to the Medicaid Act creates a right, enforceable in a private cause of action pursuant to [42 U.S.C.] § 1983, to have the State adopt rates that it finds are reasonable and adequate rates to meet the cost of an efficient and economical health care provider." 119 S.Ct. at 2525.

oppose the granting of summary judgment, Rule 56(e) provides that "an adverse party may not rest upon the mere allegations or details of the adverse party's pleadings, . . . [instead, the defending party], by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial." When all the evidence presented, by both parties, could not lead a rational trier of fact to find for the non-moving party, there is no genuine issue for trial. *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586, 106 S. Ct. 1348, 1356, 89 L. Ed. 2d 538 (1986).

The Medicaid program is a joint federal-state program which is designed to provide medical care and assistance to indigent persons. When a state elects to participate in the Medicaid program and reserve matching federal funds, the state must comply with the Medicaid statute and regulations which are promulgated by the Health Care Financing Administration (HCFA). The Boren Amendment, § 1396a(a)(13)(A), provides that each State plan must provide for the reimbursement of inpatient hospital services:

> "through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and federal laws, regulations and quality and safety standards."

Under the regulations set forth in 42 CFR § 447.253(b), the State Medicare Agency must make findings and submit assurance to HCFA that the rates are "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities." This submission must also be made to the HCFA when the plan is amended.

The plaintiffs in a Boren Amendment case have a heavy burden of proof. *Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511 (5th Cir. 1983). A "presumption of validity attaches to agency action" in a Boren Amendment case. *Id.* at 517. The district court must use an "arbitrary and capricious" standard of review when examining a state Medicaid agency's actions under the Boren Amendment.

Applying the standard set forth above, the Court finds that the State of Louisiana has adequately and properly set forth findings for the decisions it made in adopting changes in its plan during the years 1985, 1986, 1988, 1989 and 1990. These findings are set forth in exhibits 5, 6, 7, 11, and 12. In addition, the defendants have set forth affidavits in support of their motion for summary judgment which explain their findings. The evidence submitted by the defendants is uncontroverted. It is also clear that the HCFA has accepted these findings. While the decision of the HCFA to accept the state's findings is not binding on the Court, it is evidence which may be considered by the Court in determining whether adequate findings were made by the State. Therefore, the Court finds that the defendants' motion for summary judgment should be granted and the plaintiffs' motion for summary judgment should be denied.

The parties have raised other issues in the motions for summary judgment. Because the Court has found that the defendants have made adequate findings, it is not necessary for the Court to rule on these additional issues.

Therefore, the Court finds that the Court has subject matter jurisdiction in this case. The Court further finds that defendants' motion for summary judgment should be granted and plaintiffs' motion for summary judgment should be denied.

Judgment shall be entered dismissing plaintiffs' case with prejudice.

Baton Rouge, Louisiana, September 9, 1992.

s/Frank J. Polozola
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

ABBEVILLE GENERAL HOSPITAL, ET AL

CIVIL ACTION
No. 91-356-B

versus

DAVID L. RAMSEY, SECRETARY DEPARTMENT OF HEALTH AND HOSPITALS, ET AL

JUDGMENT

For the written reasons assigned:

IT IS ORDERED AND ADJUDGED that judgment shall be entered in favor of the defendants and against the plaintiffs dismissing this suit with prejudice.

Baton Rouge, Louisiana, September 14, 1992.

s/Frank J. Polozola
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

ABBEVILLE GENERAL HOSPITAL,
ET AL

CIVIL ACTION
No. 91-356-B

versus

DAVID L. RAMSEY, SECRETARY
DEPARTMENT OF HEALTH AND
HOSPITALS, ET AL

RULING ON PLAINTIFFS' MOTION FOR NEW TRIAL

This matter is before the Court on plaintiffs' motion for a new trial. The Court deletes from its first opinion the reference that the HCFA had approved the 1988 "freeze" amendment. This was a clerical error on the Court's part and has no bearing on the Court's final decision. As noted in the first opinion, the approval by the HCFA is not binding on the Court, but is evidence which may be considered by the Court.

The evidence in this case is clear that defendants are entitled to summary judgment as a matter of law. For reasons set forth in the Court's opinion, the plaintiff's motion for a new trial is DENIED.

Judgment shall be entered accordingly.

Baton Rouge, Louisiana, October 26, 1992.

s/Frank J. Polozola
UNITED STATES DISTRICT JUDGE

APPENDIX C

U.S. COURT OF APPEALS
FILED
NOV 26 1993
CHARLES R. FULBRUGE III
CLERK

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT

No. 92-3995

ABBEVILLE GENERAL HOSPITAL, ET AL.,

Plaintiffs-Appellants,

versus

DAVID L. RAMSEY, Secretary,
Department of Health and Hospitals, ET AL.,

Defendants-Appellees.

Appeal from the United States District Court
for the Middle District of Louisiana

ON PETITION FOR REHEARING

(Opinion September 22, 5th Cir., 1993, ____ 3d ___)

Before EMILIO M. GARZA, and DeMOSS, Circuit Judges.

and ZAGEL,* District Judge.

PER CURIAM:

IT IS ORDERED that the petition for rehearing filed in the above entitled and numbered cause be and the same is hereby DENIED. However, the panel opinion reported at 3 F.3d 797 is amended, by the addition of footnote 19 to the last paragraph of the opinion, as follows:

This Court cannot endorse such a *pro forma* compliance with the findings requirement of the Boren Amendment. LDHH's inability to articulate an orderly process of evaluation or to identify specific documents reviewed renders suspect its "findings" and renders meritless its argument that it engaged in a *bona fide* findings process. Because we find that LDHH, as a matter of law, failed to comply in practice with the Boren Amendment findings requirement, this Court REVERSES the district court's grant of LDHH's summary judgment motion and denial of the Hospitals' summary judgment motion. This case is REMANDED for proceedings not inconsistent with this opinion.[19]

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* District Judge of the Northern District of Illinois, sitting by designation.

[19] We express no view on whether the Hospitals' summary judgment motion may be defeated, in part or in whole, by various affirmative defenses which were neither ruled on in the district court nor argued in this Court.

APPENDIX D

42 U.S.C. § 1396a(a)(13)(A)

Section 1396a(a)(13)(A) of Title 42, United States Code, provides, in part:

> a State plan for medical assistance must
>
> . . . .
>
> provide . . . for payment . . . of hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality.

* * * * *

42 U.S.C. § 1983

Section 1983 of Title 42, United States Code, provides, in part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of

any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

* * * * *

42 C.F.R. § 447

Section 447.253 of Title 42, Code of Federal Regulations, provides, in part:

(a) *State assurances.* In order to receive HCFA approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (i) of this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) *Findings.* Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:

(1) *Payment Rates.* (i) The Medicaid agency pays for inpatient services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

(ii) With respect to inpatient hospital services —

(A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs;

. . . .

(C) The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

* * * * *

Section 447.255 of Title 42, Code of Federal Regulations, provides:

The Medicaid agency must submit, with the assurances described in § 447.253(a), the following information:

(a) The amount of the estimated average proposed payment rate for each type of provider (hospital, ICF/MR, or nursing facility), and the amount by which that estimated average rate increased or decreased relative to the average payment rate in effect for each type of provider for the immediately preceding rate period;

(b) An estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on —

(1) The availability of services on a Statewide and geographic area basis;

(2) The type of care furnished;

(3) The extent of provider participation; and

(4) The degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

* * * * *

Section 447.256(a)(2) of Title 42, Code of Federal Regulations, provides:

In the case of State plan and plan amendment changes in payment methods and standards, HCFA bases its approval on the acceptability of the Medicaid agency's assurances that the requirements of § 447.253 have been met, and the State's compliance with the other requirements of this subpart.